Please mail the registration forms to:
The Stern Center for Aesthetic Surgery, PC, 1370 116th Avenue NE, Suite 102, Bellevue, WA 98004

The Stern Center for Aesthetic Surgery, P.C.

PRE-HISTORY FORM **PATIENT NAME**_____

1. Has your present physician requested you to be seen at The Stern Center for Aesthetic Surgery? If so, their name and address:_____

_____

2. State in your own words the major medical reason(s) for coming to The Stern Center for Aesthetic Surgery.

_____

_____

_____

_____

3. Please list all medicines that you use. _____

_____

_____

4. Family History: Please indicate the health or cause of death of members of your family as best you can:

	AGE IF LIVING	AGE AT DEATH	INDICATE ANY SERIOUS DISEASES	CAUSE OF DEATH
Mother				
Father				
Brothers				
Sisters				
Children				
Spouse				

Indicate which of your relatives have had any of the following diseases:

Cancer: _____ Diabetes: _____
Heart Trouble; _____ High Blood Pressure: _____
Kidney Disease: _____ Mental or Emotional Disease: _____
Strokes: _____ Tuberculosis: _____
Arthritis: _____

5. Please indicate by checking "yes" or "no" if you have had significant problems in the below areas. Please comment on special problems:

YES	NO	Nature of Problem	COMMENT and give approximate date
		Recent weight loss	
		Headaches	
		Trouble with vision	
		Trouble with hearing	

YES	NO	Nature of Problem	COMMENT and give approximate date
		Allergies - - Hayfever	
		Allergic Reaction to Medications? Which Ones?	
		Thyroid (goiter)	
		Diabetes	
		Skin	
		Anemia or Abnormal Bleeding	
		Heart	
		Circulation	
		Chest Pain	
		Lungs (pneumonia, T.B. etc)	
		Shortness of breath – cough Pleurisy, Wheezing	
		Liver disease, Gallbladder disease or Jaundice	
		Stomach trouble – Ulcers, Indigestion, change in bowel habits, Constipation or Diarrhea	
		Abdominal pain	
		Kidney disease or stones	
		Urination problems	
		Female organs	
		Joint pain or stiffness	
		Phlebitis	
		Do you smoke? How much?	
		Do you drink alcoholic beverages? How much?	
		Depression	
		Nerves	
		Psychiatric	
		Fainting or Convulsions	
		Strokes	
		Pain in other areas	
		Other Illness or Problem	

6. Please give details of any - Approximate date Surgeon Hospital

Operations -

Serious Injuries –

7. Please feel free to attach any other recorded information which you feel will be of importance to the doctor in evaluating your health problems.